LOUISIANA PATIENT'S COMPENSATION FUND

ADDITIONAL INSURED ADDENDUM

(for those with underlying self-insurance and primary insurance)

NAME AND PHYSICAL ADDRESS OF PRIMARY HEALTHCARE PROVIDER

_____

_____

_____

_____

DATES OF ENROLLMENT APPLYING FOR:_____

(Must coincide with dates of underlying coverage)

LIST ALL ADDITIONAL INSUREDS AND THEIR RELATION TO THE ABOVE:

(Use additional page if necessary)

NAME & PHYSICAL ADDRESS	RELATIONSHIP (off site clinics or centers, additional corporate entities, owners, practice groups or organizations, etc.)

As a self insured, I further certify that the appropriate security (proof of financial responsibility) is in place and current at _____..

For those with primary insurance, please provide a copy of the COI or declarations page from the insurer's policy.

SIGNATURE OF AUTHORIZED REPRESENTATIVE: _____

DATE: _____

CONTACT PERSON AND PHONE #:_____

CONTACT EMAIL ADDRESS:_____

Complete and return to: **Patient's Compensation Fund**
P. O. Box 3718
Baton Rouge, LA 70821
(225) 362-5265 - Fax